

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

043:1

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY Dorchester		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge R.F.D.			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		
LENGTH OF STAY (In this place) All life			STREET (If rural, give location) ADDRESS 51 A Douglas Street		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bucktown Rd.					
3. NAME OF DECEASED (Type or Print)	(First) Clarence	(Middle)	(Last) Ames	4. DATE OF DEATH Jan. 21	(Month) (Day) (Year) 19 51
5. SEX Male	6. COLOR OR RACE Black	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH 9-22-1926	9. AGE last birthday 24 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Any labor	11. BIRTHPLACE (State or foreign country) Teller, Virginia	
13. FATHER'S NAME Chauncey Lee Ames			12. CITIZEN OF WHAT COUNTRY U.S.A		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) yes World War 2			16. SOCIAL SECURITY NO. 16. SOCIAL SECURITY NO.	17. INFORMANT Sally Garrison	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

8225 Immediate cause (a) **Intracranial injury** Instant.

1700 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last
(b) **Multiple fractures of skull.**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Highway	(CITY OR TOWN) Nr. Cambridge Md.	(COUNTY) Dor.	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 1 21 51 2 p.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Was passenger in auto which overtrne		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John Mace Jr. Deputy Medical Examiner

M. D.

Cambridge, Maryland

1-23-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-28-51	NAME OF CEMETERY OR CREMATORIY Wall Methodist Cemetery	LOCATION (City, town, or county) (State) Cambridge, Md.
DATE REC'D BY LOCAL REG. 1-23-51	REGISTRAR'S SIGNATURE John Mace, Jr., M. D.	24. FUNERAL DIRECTOR Lewis H. Baynue	ADDRESS Cambridge, Md.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0440

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Caroline		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Federalsburg		
TOWN Cambridge (near)			15 MOS.	(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital			12		
3. NAME OF DECEASED (Type or Print)	(First) May	(Middle) -	(Last) Bowdle	4. DATE OF DEATH	(Month) 1 (Day) 3 (Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 5-9-1871	9. AGE last birthday 79 yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Bowdle			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --			16. SOCIAL SECURITY NO. --	17. INFORMANT AND ADDRESS Eastern Shore State Hospital records	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Cerebral Hemorrhage 12-28-50 443X Antecedent cause(s) Hypertensive Cardio-Vascular Disease ? 93d Diseases or conditions, if any, giving rise to the above cause (b) stating the underlying cause last (c) Senile Psychosis with Arteriosclerosis 1942					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While At work	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-7-, 1950 to 1-3, 1951, that I last saw the deceased alive on 1-2, 1951, and that death occurred at 7:30 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan. 5, 1950	NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery	LOCATION (City, town, or county) (State) Federalburg, Maryland		
DATE REC'D BY LOCAL REG. 5, 1951	REGISTRAR'S SIGNATURE John Mace Jr. n.s.		24. FUNERAL DIRECTOR ADDRESS J. J. Frampton and Son, Federalburg, Maryland		



Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0441

ALM No. G 130 JAN 16 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH. COUNTY Dorchester			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE MARYLAND Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge		LENGTH OF STAY (in this place) 111e	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		COUNTY Dorchester
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 High Street			STREET ADDRESS 21 High Street		
3. NAME OF DECEASED (Type or Print) Sarah		(First) (Middle) Wright	(Last) Dail	4. DATE OF DEATH Jan. 7	(Month) (Day) (Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED	8. DATE OF BIRTH 4-30-1874	9. AGE last birthday 76 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME R. T. Wright			14. MOTHER'S MAIDEN NAME Edith Giles		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS Mr. Calvin Dail, New York, N.Y.		
18. MEDICAL CERTIFICATION					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X Immediate cause

(a) *Congestive Heart Failure & Pulmonary edema*

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

131a Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) *arteriosclerotic Cardiovascular Disease*

1 year

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

No

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT
SUICIDE
HOMICIDE
No

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Not While
m. Work At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5-24*, 1950, to *Jan 7*, 1951, that I last saw the deceased
alive on *Jan 6*, 1951, and that death occurred at *4:48 A.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Eldridge H. Wolff, M.D.

Cambridge Maryland

1-8-51

23. BURIAL, CREMATION
REMOVAL
(Specify)
Burial

DATE THEREOF
1-9-51

NAME OF CEMETERY OR CREMATORIUM
Christ Church Cemetery

LOCATION (City, town, or county) (State)
Cambridge, Maryland

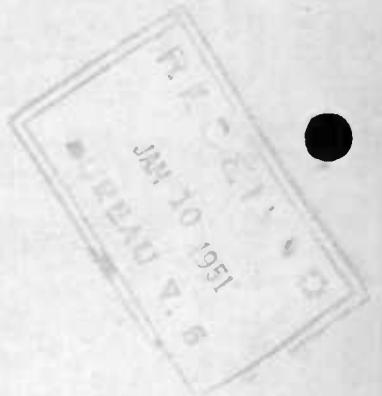
DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE
John Mace Jr. MD

24. FUNERAL DIRECTOR

ADDRESS

LeCompte Funeral Service, Cambridge, Md



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0442

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
Dorchester MARYLAND		Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	STREET ADDRESS
Cambridge		Cambridge	115 Choptank Ave
HOSPITAL OR INSTITUTION OR STREET ADDRESS	115 Choptank Ave		
3. NAME OF DECEASED (Type or Print)	(First) Guy	(Middle) Burton	(Last) Dean
4. DATE OF DEATH	(Month) Jan	(Day) 2	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Single	12-28-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs.	If under 1 year Months Days Hours Min.
Waterman		61	
13. FATHER'S NAME	11. BIRTHPLACE (State or foreign country)		
Charles A. Dean	Cambridge Md		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY?	
yes	123-45-6789	US	
17. INFORMANT			
Carl Louis, Choptank Ave, Cambridge, Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 420.1		Coronary occlusion 5 min	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d		Hypertension, cardiac disease? diabetes	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
INJURY	TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> m. <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . SIGNATURE John Moore, M.D. ADDRESS 200. Cambridge Md. DATE SIGNED 1/3/51 (Degree or title)			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG. Jan 3, 1951	REGISTRAR'S SIGNATURE John Moore, J.P., M.D.	FUNERAL DIRECTOR Kenneth L. Thomas	ADDRESS 910 126 Md.
24. FUNERAL DIRECTOR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

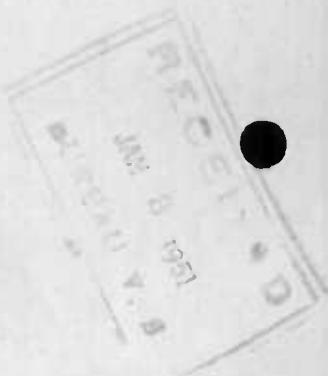
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0443

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge		LENGTH OF STAY (In this place) 45 yrs	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 330 Washington Street		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge	
3. NAME OF DECEASED (First) SALLIE (Type or Print)		(Middle) MOIRA TYLER (Last) HENRY	
4. DATE OF DEATH JAN 4 1951	(Month)	(Day)	(Year)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED (Specify) Married	8. DATE OF BIRTH 11/4/1880
9. AGE last birthday 70 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jackson Tyler		14. MOTHER'S MAIDEN NAME Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Lee Henry, (See No # 2)		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX Immediate cause (a) Cerebral hemorrhage 83a Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. INJURY		PLACE (Home, farm, factory, street, (CITY OR TOWN) (COUNTY) (STATE) OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE John MacEachen Deputy Medical Examiner Dorchester County.		ADDRESS M.D. Cambridge, Md. (Degree or title)	
DATE SIGNED 1/4/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/7/1951	
NAME OF CEMETERY OR CREMATORIAL REG. Greenlawn Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REG. Jan. 5, 1951		REGISTRAR'S SIGNATURE John Mac. Jr., M.D.	
24. FUNERAL DIRECTOR LeCompte Funeral Service		ADDRESS	
Cambridge, Maryland			



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0444

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Darchester</u>		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Delaware</u> COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Georgetown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sh Ctr</u>		STREET ADDRESS <u>R. F. D. 5</u>		

3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Frank</u>	(Last) <u>Hudson</u>	4. DATE OF DEATH <u>Jan 15</u>	(Month) <u>Jan</u>	(Day) <u>15</u>	(Year) <u>1951</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-15-1923</u>	9. AGE last birthday yrs. <u>27</u>	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Turner</u>	10b. KIND OF INDUSTRY <u>own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Georgetown Del</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13. FATHER'S NAME <u>Charles W. Hudson</u>	14. MOTHER'S MAIDEN NAME <u>Selma C. Donovan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>W 111-00-0000</u>	17. INFORMANT <u>Lloyd W. Hudson Georgetown</u>
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18. MEDICAL CERTIFICATION		
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1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>925.3</u>	2. INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
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Immediate cause <u>Suffocation</u>	(a)
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Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>182</u>	(b)
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(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OFFICE bldg., etc.) <u>Injury Saw mill</u>	(CITY OR TOWN) <u>Cambridge</u>	(COUNTY) <u>Dor.</u>	(STATE) <u>Md.</u>
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TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan 15 51 11a.m.</u>	INJURY OCCURRED While at Not while work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Pile of saw dust caved in on him.</u>
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22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .	DATE SIGNED <u>1/16/51</u>
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SIGNATURE <u>John Mace Jr. M.D.</u>	ADDRESS
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Deputy Medical Examiner	Cambridge, Md.	DATE SIGNED <u>1/16/51</u>
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23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <u>Buried Jan 18 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Mechanics Cemetery</u>	LOCATION (City, town, or county) <u>Wellsboro</u>	(State) <u>Del.</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REC. <u>Jan. 16/51 John Mace Jr. M.D.</u>	FUNERAL DIRECTOR ADDRESS
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<u>Ronald James Wellsboro Del</u>	
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Kenneth R. Thomas Cambridge Del



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge		LENGTH OF STAY (in this place) 11 th		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		STREET ADDRESS (If rural, give location) Roslyn Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Roslyn Avenue							
3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) K.	(Last) HURLEY	4. DATE OF DEATH JAN 23 1951	(Month) JAN	(Day) 23	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5/22/1904	9. AGE last birthday 46 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Construction--		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John L. Hurley				14. MOTHER'S MAIDEN NAME Minnie C. Orem			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. not known		17. INFORMANT Viola R. Hurley, Cambridge, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331x Immediate cause 83a Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last		5 min	
(a) Cerebral Hemorrhage			
(b)			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		DATE SIGNED 1-24-51	
SIGNATURE Edridge & Wolff, M.D.		(Degree or title) ADDRESS 1001 Cambridge St., Cambridge, Md.	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/26/1951	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Dorchester Memorial Park, Cambridge, Md.		(State)	
DATE REC'D BY LOCAL REG. 1-25-51		REGISTRAR'S SIGNATURE John Dranege, M.D.	
24. FUNERAL DIRECTOR LeCompte Funeral Service,		ADDRESS Cambridge, Maryland 970246	





MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 110

0447

1. PLACE OF DEATH: COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town)		LENGTH OF STAY (In this place)		Maryland		COUNTY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<i>Williamsburg All Day</i>				<i>087</i>	

3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
---------------------------------------------------------------------------------------------	--------------------------------------	-------------------------------------------	---------------------------------

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT
	<i>214-28-313</i>	<i>Mary Rose Cephas</i>

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

8 hrs.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause	(a) <i>Coronary occlusion</i>
Antecedent cause(s)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>94a</i>
	(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
------------------------	----------------------------------	--------------

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> m. <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John Rose Jr. MD. Cambridge Md. *1/17/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
--------------------------------------------	--------------	---------------------------------	----------------------------------	---------

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REC'D	24. FUNERAL DIRECTOR ADDRESS		
----------------------------------------------------	------------------------------	--	--

<i>Jan 19, 1951</i>	<i>J. J. Grampian and Son, Federalsburg, Maryland</i>		
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REC'D	ADDRESS		
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<i>Chas W Hastings</i>	<i>970609</i>		
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Boone Co.

Yerba grande

Plant with small leaves
in clusters and small flowers

Leaves opposite, serrated,
yellow-green, flowers yellow

Leaves opposite, serrated,

Leaves opposite, serrated



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 110

0448

1. PLACE OF DEATH COUNTY Dorchester		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Rural - Hurlock		LENGTH OF STAY (in this place) Life	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS Rural - Hurlock Cabin Creek	
3. NAME OF DECEASED (Type or Print)	(First) Fred	(Middle)	(Last) Jews
4. DATE OF DEATH January 2 1951	(Month)	(Day)	(Year)
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH September 22, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Horace Jews	14. MOTHER'S MAIDEN NAME Martina Johnson	17. INFORMANT AND ADDRESS Catherine Elbert - Hurlock, Md. R + D.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. no	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause	(a) Coronary thrombosis	1 week	
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General arteriosclerosis	5 yrs +	
	(c) Atrial fibrillation	1 week.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 27, 1950 , to Jan. 2, 1951 , that I last saw the deceased alive on Dec. 27, 1950 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above.			
SIGNATURE W.C. Garrison MD	(Degree or title) ADDRESS Hurlock, Md.	DATE SIGNED 1/6/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan 6 1951	NAME OF CEMETERY OR CREMATORIAL washington (closed)	LOCATION (City, town, or county) Hurlock
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REC. Jan 6-1951 Chesapeake & Hastings	24. FUNERAL DIRECTOR J. J. Frampton & Son	(State) federal bus and 820 105	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

0443

1. PLACE OF DEATH COUNTY Dorchester			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge (rural)			LENGTH OF STAY (in this place)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perryville		
3. NAME OF DECEASED (Type or Print) Sarah			4. DATE OF DEATH Jan. 4 1951		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 7-15-1883	9. AGE last birthday 67	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY --		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Millard Weaver			14. MOTHER'S MAIDEN NAME Louise Singleton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --			16. SOCIAL SECURITY NO. --		
17. INFORMANT AND ADDRESS Eastern Shore State Hospital records			18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 12-27-50		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 5020	(a) Edema of the Lungs	12-27-50
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Bd	(b) Chronic Bronchitis, emphysema, Hypertensive Cardio-Vascular Disease	1940
	(c) Psychosis with Convulsive Disorders	1929

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-7-1950, to 1-4-1951, that I last saw the deceased

alive on 1-4-1951, and that death occurred at 7:03 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-7-51	NAME OF CEMETERY OR CREMATORIAL Dublin Cemetery	LOCATION (City, town, or county) Dublin, Harford Co. Md.
DATE REC'D BY LOCAL REG. Jan. 5, 1951	REGISTRAR'S SIGNATURE John MacLean, Jr., M.D.	24. FUNERAL DIRECTOR Lee A. Patterson & Son	ADDRESS Perryville, Maryland 720826



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

0450

1. PLACE OF DEATH COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Andrews		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Andrews		STREET ADDRESS (If rural, give location) (none)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS (none)							
3. NAME OF DECEASED (Type or Print)	(First) IDA	(Middle) WROTEM	(Last) MOORE	4. DATE OF DEATH	(Month) JAN	(Day) 20	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH unknown yrs.	9. AGE last birthday unknown yrs.	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME not known		14. MOTHER'S MAIDEN NAME not known					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS Mrs. John Jones, Andrews, Md.				
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Myocardial Failure Antecedent cause(s) (b) Bronchopneumonia Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last stating the underlying cause last (c) 2 days. Bronchial Rt Hemiplegia 3 weeks.							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	(Specify) PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY)	(STATE)		
		HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 1/17, 1950, to 1/20, 1951, that I last saw the deceased alive on 1/9/51, and that death occurred at (Degree or title) m., from the causes and on the date stated above. SIGNATURE <i>J. D. Andrews Jr. M.D.</i> ADDRESS Cambridge, Md. DATE SIGNED 1/22/51							
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1/22/1951	NAME OF CEMETERY OR CREMATORIAL Family burial lot	LOCATION (City, town, or county) Andrews, Maryland	(State)			
DATE REC'D BY LOCAL REG. Jan. 22, 1951	REGISTRAR'S SIGNATURE <i>John Maca Jr. M.D.</i>	24. FUNERAL DIRECTOR LeCompte Funeral Service,	ADDRESS				
Cambridge, Maryland							

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The *correct age* is especially important. Physicians: please write the causes of death clearly and legibly.

MANAGIN RESERVE FOR BINDING

VSA 15



0451

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 110

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Dorchester		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)	
TOWN		35 years	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
RFD #1		RFD #	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
Male	Howard		Perkins
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
Male	Colored	Never married	3/17/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm labor	own Farming	Denton - Maryland	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Unknown	Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. MEDICAL CERTIFICATION
No	none	Roxie Perkins Daughter	Coronary Occlusion Arteriosclerotic Cardio-Vascular Disease 15 min.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a) Coronary Occlusion

93d Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

(b) Arteriosclerotic Cardio-Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

None

INTERVAL BETWEEN
ONSET AND DEATH

15 min.

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING OF
CAUSE OF DEATH.

PLACE (Home, farm, factory, street,
office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURY

While at
work Not while
at work

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereto and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Eldridge H. Wolff, M.D., *Resident Medical Examiner, Dorchester County*

1-29-57

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

Jan 31, 1957

Hurlock Cemetery

Hurlock

md

DATE REC'D BY LOCAL
REG. OFFICE

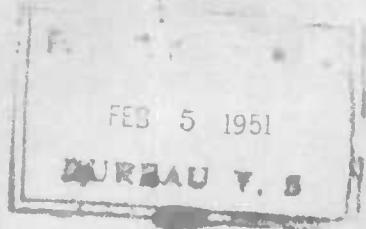
RECORISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Chas. Hastings

G. B. Kilbough, Jr. Hurlock



0452

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Vienna LENGTH OF STAY (in this place) Lite			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Vienna STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED (Type or Print)	(First) Rufus	(Middle) A.	(Last) Pinkett	4. DATE OF DEATH January 17	(Month) (Day) (Year) 1951
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH June 15, 1891	9. AGE last birthday 59 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Stationary Boiler Canning Factory			10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Md.		
13. FATHER'S NAME Alexander Pinkett			14. MOTHER'S MAIDEN NAME Lucy Blake		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No			16. SOCIAL SECURITY NO. 217-05-7931		
17. INFORMANT AND ADDRESS Ethel B. Pinkett, Vienna, Maryland			18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 Immediate cause (a) Chronic Myocardial Degeneration 5 yrs + 93d Antecedent cause(s) General arteriosclerosis 5 yrs + Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 1945, to Jan. , 1951, that I last saw the deceased alive on Jan. 7, 1951, and that death occurred at 8 A.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED W.C. Harrison MD Hurlock Md. 1/19/51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Jan. 21, 1951		NAME OF CEMETERY OR CREMATORIAL Vienna Col. Cemetery LOCATION (City, town, or county) Vienna, Maryland (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE Jan. 21, 1951 Elizabeth H. Craft		24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md. ADDRESS 680408	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

SEARCHED

JUN 23 1951

SEARCHED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0453

Reg. Dist. No. 116

1. PLACE OF DEATH: COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Dor.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge LENGTH OF STAY (in this place) all life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge STREET ADDRESS Washington St.	
HOSPITAL OR INSTITUTION OR Market St. STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) Lateeny (Middle)	(Last) Rideout	4. DATE OF DEATH January 10 1951
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 5, 1883 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) oyster shucker		10b. KIND OF BUSINESS OR INDUSTRY Oysterhouse	9. AGE last birthday If under 1 year Months Days Hours Min. yrs.
13. FATHER'S NAME George W. Harris		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
		17. INFORMANT Chelsea Caldwell Cambridge Md. #1	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>420.1 Immediate cause (a) Coronary occlusion</p> <p>94a Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last</p> <p>(c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . SIGNATURE John Mace, Jr., M.D. (Degree or title) ADDRESS DATE SIGNED Deputy Medical Examiner Cambridge, Md. 1/19/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-23-51	NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	LOCATION (City, town, or county) (State) Cambridge, Maryland
DATE REC'D. BY LOCAL REG. 1-23-51	REGISTRAR'S SIGNATURE John Mace, Jr., M. D.	24. FUNERAL DIRECTOR Lewis H. Bayneum	ADDRESS Cambridge, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

6454

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY Dorchester		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 Glasgow Street		STREET ADDRESS 100 Glasgow Street		(If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print) SARAH		(Middle) WINGATE		(Last) SEWELL	
4. DATE OF DEATH JAN 20 1951		5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 3/14/1868		9. AGE last birthday 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas H. Wingate		14. MOTHER'S MAIDEN NAME Mary Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Mrs. Daisey Sewell, Cambridge, Md.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>420.1 Immediate cause (a) Coronary Thromboses Sudden</p> <p>93d Antecedent cause(s) (b) Arteriosclerosis Generalized 10 years</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Myocarditis Chronic 5 years</p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1948, to Dec 1951, that I last saw the deceased alive on 20th Dec 1951, and that death occurred at 7 a.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED Jan 22/51					
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/22/1951		NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery LOCATION (City, town, or county) Cambridge, Maryland (State)	
DATE REC'D BY LOCAL REG. KEG. Jan. 22, 1951		REGISTRAR'S SIGNATURE John Macay MD.		24. FUNERAL DIRECTOR LeCompte Funeral Service, ADDRESS Cambridge, Maryland	



MARGIN RESERVED FOR BINDING

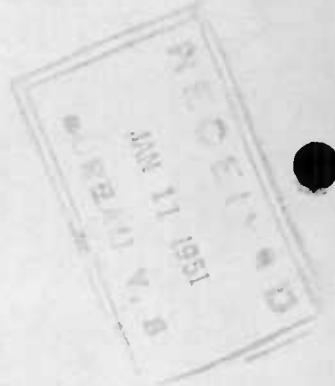
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0455

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <i>Cambridge Dorchester Co</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Cambridge</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cambridge Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>113 Miner St</i>		STREET ADDRESS <i>(If rural, give location)</i> <i>113 Miner St</i>	
3. NAME OF DECEASED (First) <i>Samuel Columbus</i>	(Middle) <i>Short</i>	4. DATE OF DEATH <i>Jan 8</i>	(Month) <i>Jan</i> (Day) <i>8</i> (Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1863</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	9. AGE last birthday <i>87</i>	If under 1 year <i>7</i> Months Days Hours Min.
13. FATHER'S NAME <i>William Short</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Daughter (Maud Sanders)</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause <i>Cerebral Apoplexy</i> 334X Antecedent cause(s) <i>Arteriosclerosis Generalized</i> 83a Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <i>(b) (c)</i></p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>Hugh Brown</i>	(Degree or title) <i>MD</i>	ADDRESS <i>Cambridge</i>	DATE SIGNED <i>Jan 8, 1951</i>
23. BURIAL, Cremation REMOVAL (Specify) <i>Feb 11, 1951</i>	DATE THEREOF <i>Feb 11, 1951</i>	NAME OF CEMETERY OR CREMATORIUM <i>East New Market</i>	LOCATION (City, town, or county) <i>East New Market</i> (State) <i>Md</i>
DATE REC'D BY LOCAL REG. <i>1-10-51</i>	REGISTRAR'S SIGNATURE <i>John Maca Jr MD</i>	24. FUNERAL DIRECTOR <i>H.B. Halloway</i>	ADDRESS <i>100105</i>



0456

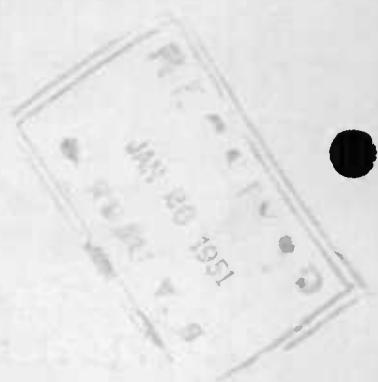
**MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS**

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)					
TOWN		Cambridge		TOWN		Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		306 Maryland Ave		STREET ADDRESS		306 Maryland Ave			
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)	
Male white		Melton	Sullivan	Sullivan	Jan 23	1951			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
Male white		white		Married		July 18-1861		59 yrs.	If under 1 Year Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired Grocer		None		Caroline County		US			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
James Sullivan		Emily Wright							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. MEDICAL CERTIFICATION			
No		None		Mrs. Ida Sullivan-Cambridge					

MARGIN RESERVED FOR BINDING

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a).....		3 days	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b).....		2 weeks	
186a					
186a					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY 1 8 51 7 AM		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? Slipped and fell to floor	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
SIGNATURE		(Degree or title)		ADDRESS	
John Moore M.D.				DATE SIGNED 1/24/51	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF Jan 26-1951		NAME OF CEMETERY OR CREMATORIAL Cambridge	
DATE REC'D BY LOCAL REG. 1-25-51		REGISTRAR'S SIGNATURE John Moore Jr. M.D.		LOCATION (City, town, or county) Cambridge	
24. FUNERAL DIRECTOR				ADDRESS Reverend R. Shores Cambridge	
				20636	



L. M.

MARYLAND STATE DEPARTMENT OF HEALTH

045

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hudson		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hudson		STREET ADDRESS (If rural, give location) (none)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS (none)							
3. NAME OF DECEASED (Type or Print) CLARA		(First) (Middle) FIGGS		(Last) THOMAS		4. DATE OF DEATH JAN 12 1951	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married		8. DATE OF BIRTH 10/13/1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		9. AGE last birthday 76 yrs.	
13. FATHER'S NAME James B. Figgs				14. MOTHER'S MAIDEN NAME Amanda Wheeler		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Everett Thomas, Easton, Maryland			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause 181x		(a).....		Bronchogenic carcinoma		INTERVAL BETWEEN ONSET AND DEATH 8 months	
Antecedent cause(s) Diseases or conditions, if any, 521 giving rise to the above cause stating the underlying cause last		(b).....		Carcinoma of urinary bladder		8 months	
		(c).....					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work At work		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 10, 1950, to Jan 13, 1951, that I last saw the deceased alive on Jan 9, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED 1/15/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/16/1951		NAME OF CEMETERY OR CREMATORIAL Memorial Park, Cambridge, Maryland		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 1-16-51		REGISTRAR'S SIGNATURE John Mace		24. FUNERAL DIRECTOR LeCompte Funeral Service,		ADDRESS	
—Cambridge, Maryland							

Jan 19 1951



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0458

CERTIFICATE OF DEATH

Reg. Dist. No. 111

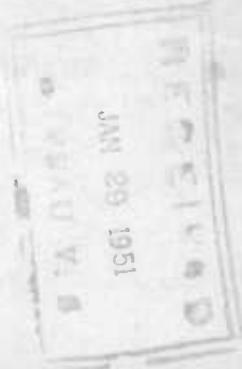
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Dorchester		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN East New Market - Rural		LENGTH OF STAY Life	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Thompsonstown		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN East New Market - Rural	
3. NAME OF DECEASED (Type or Print) William		4. DATE OF DEATH January 19 1951	
(First) W.		(Month) January	
(Middle)		(Day) 19	
(Last) Thompson		(Year) 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH April 18, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
13. FATHER'S NAME John W. C. Thompson		11. BIRTHPLACE (State or foreign country) Dorchester County, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY U.S.A.	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME Susan A. Jackson	
17. INFORMANT AND ADDRESS Hattie S. Thompson, East New Market, Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>420.0 Immediate cause (a) <i>Cerebral hemorrhage</i> 4 days</p> <p>93d Antecedent cause(s) <i>Arterio sclerotic Heart Disease</i> unknown</p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (b) _____</p> <p>(c) _____</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work At work	
OF INJURY m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12/31, 1950</i> , to <i>1/19, 1951</i> , that I last saw the deceased alive on <i>1/15, 1951</i> , and that death occurred at <i>9:45 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS DATE SIGNED	
<i>Laurence Mariano M.D.</i>		<i>Cambridge, Md 1/20/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Jan. 22, 1951	
NAME OF CEMETERY OR CREMATORIAL Thompsonstown Cemetery		LOCATION (City, town, or county) Near East New Market, Md.	
VS. A15		DATE REC'D BY LOCAL REG.	
REG.		REGISTRAR'S SIGNATURE	
<i>1/21/51</i>		<i>Elizabeth C. Smith</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>J.J. Frampton and Son, Federalsburg, Md.</i>			

100105



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0459

CERTIFICATE OF DEATH

Reg. Dist. No. 116

AM No. G 130 FEB 14 1951

1. PLACE OF DEATH COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Cambridge</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cambridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>30 Skinner Court</i>		STREET ADDRESS <i>Skinner Court 30</i>	
3. NAME OF DECEASED (Type or Print) <i>Oliver Thompson</i>		4. DATE OF DEATH <i>Jan 30 1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED, <i>Widowed</i> (Specify)	8. DATE OF BIRTH <i>March 1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmhand</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. FATHER'S NAME <i>William Thompson</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT AND ADDRESS <i>Bonnie Thompson</i>		18. MEDICAL CERTIFICATION <i>Obstetrical</i>	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Anteplacental</i>		INTERVAL BETWEEN ONSET AND DEATH	

434.1 Immediate cause (a) *Anteplacental*932 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last (b) *None*
(c) *None*II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work	HOW DID INJURY OCCUR? Not While At work	
m.					

22. I hereby certify that I attended the deceased from *1-28-1951*, to *1-30-1951*, that I last saw the deceasedalive on *1-29-1951*, and that death occurred at *3:30 p.m.*, from the causes and on the date stated above.
SIGNATURE *John Mace Jr. M.D.* ADDRESS *233 Cedar St. Md. 2-3-7* DATE SIGNED *2-4-51*

23. BURIAL, Cremation REMOVAL (Specify) <i>Burial</i>	DATE THEREON <i>2-4-51</i>	NAME OF CEMETERY OR CREMATORY <i>Taylor's Island Cemetery</i>	LOCATION (City, town, or county) <i>Taylor's Island</i>	(State) <i>Md.</i>
DATE REC'D BY LOCAL REG. <i>2-4-51</i>	REGISTRAR'S SIGNATURE <i>John Mace Jr. M.D.</i>	24. FUNERAL DIRECTOR ADDRESS <i>Lewis H. Bayne Cambridge Md.</i>		

523 408



MARYLAND STATE DEPARTMENT OF HEALTH

C460

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 111

1. PLACE OF DEATH. COUNTY Dorchester		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN East New Market		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN East New Market	
LENGTH OF STAY (In this place) All life		STREET (If rural, give location) ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)	
Jeremiah Fletcher Varnes			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	4. DATE OF DEATH 1/17 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None (invalid)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>William Varnes</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Sallie Varnes (Sister)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATHImmediate cause *430.1* (a) Coronary occlusion

5 Min.

Antecedent cause(s)

Diseases or conditions, if any, (b) giving rise to the above cause, stating the underlying cause last
94a (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
------------------------	----------------------------------	--------------

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes accident , suicide , homicide , undetermined .

SIGNATURE *John Moore* (Degree or title) M.D. ADDRESS Cambridge, Md.
Deputy Medical Examiner

DATE SIGNED 1/18/51

23. BURIAL, Cremation Removal (Specify)	DATE THEREOF 1/20/51	NAME OF CEMETERY OR CREMATORIAL East New Market	LOCATION (City, town, or county) East New Market, Dor. Co.	(State)
--------------------------------------------	-------------------------	----------------------------------------------------	---------------------------------------------------------------	---------

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>Elizabeth C Smith</i>	24. FUNERAL DIRECTOR ADDRESS G. B. Willoughby East New Market, Md.
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JAN 29 1951



MARYLAND STATE DEPARTMENT OF HEALTH

0461

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

116

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Dorchester		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge Md. Hospital		STREET ADDRESS 222 Cedar St.		
3. NAME OF DECEASED (Type or Print) Curtis	(First)	(Middle)	(Last) Whitlock	4. DATE OF DEATH Jan. 12 1951
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Sept. 1, 1916	9. AGE last birthday 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lebaser		10b. KIND OF BUSINESS OR INDUSTRY enk.	11. BIRTHPLACE (State or foreign country) Sa.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Plummer Whitlock		14. MOTHER'S MAIDEN NAME Marty		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT AND ADDRESS Richard Whitlock - Portsmouth Virginia		18. MEDICAL CERTIFICATION Myocardial Failure Bronchial asthma		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 241x Immediate cause (a) Myocardial Failure 112 Antecedent cause(s) (b) Bronchial asthma Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Week.				
INTERVAL BETWEEN ONSET AND DEATH 3?				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Jan. 5, 1951 to Jan. 12, 1951 , that I last saw the deceased alive on 1/12/51 , 19....., and that death occurred at 5:05 a.m. from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED John Moore Jr Cambridge, Md. 1/14/51				
23. BURIAL, CREMATION REMOVAL (Specify) Funeral	DATE THEREOF 1-17-51	NAME OF CEMETERY OR CREMATORIAL Dorchester Md.	LOCATION (City, town, or county) Dorchester Md.	(State) Jmd.
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE John Moore Jr MD	24. FUNERAL DIRECTOR Lewis G. Henry Cambridge	ADDRESS 970 W. 7th St. Cambridge



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10:50 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0462

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY Dorchester		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge			LENGTH OF STAY (in this place)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 Cedar Street			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		
3. NAME OF DECEASED (Type or Print) DELIA ABBOTT			4. DATE OF DEATH JAN 15 1951		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/16/1873	9. AGE last birthday 77 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		
13. FATHER'S NAME William Abbott			11. BIRTHPLACE (State or foreign country) Maryland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			12. CITIZEN OF WHAT COUNTRY U.S.A.		
16. SOCIAL SECURITY NO. none			14. MOTHER'S MAIDEN NAME Not Known		
17. INFORMANT AND ADDRESS Frank Willey-- Cambridge, Md.			18. MEDICAL CERTIFICATION <i>Coronary occlusion Arterio sclerotic Heart Disease</i> 2 who. unknown		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) 420.0 Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last 93d (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/> m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 30, 1950</i> , to <i>Jan 15, 1951</i> , that I last saw the deceased alive on <i>Jan 15, 1951</i> , and that death occurred at <i>10:50 P.M.</i> , from the causes and on the date stated above. SIGNATURE <i>Laurence Maranoor m.d.</i> ADDRESS <i>Cambridge, Md</i> DATE SIGNED <i>1/18/51</i>					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/18/51		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Dorchester Memorial Park, Cambridge, Maryland (State)	
DATE REC'D BY LOCAL REC'D Jan. 18, 1951		REGISTRAR'S SIGNATURE <i>John Maco Jr. M.D.</i>		24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service Cambridge, Maryland	



MARYLAND STATE DEPARTMENT OF HEALTH

8463

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bucktown			LENGTH OF STAY (in this place) 111e		
HOSPITAL OR INSTITUTION OR STREET ADDRESS (none)			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bucktown		
3. NAME OF DECEASED (Type or Print) EDITH LOWE WILLEY			4. DATE OF DEATH JAN 12 1951		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED (Specify) WIDOWED	8. DATE OF BIRTH 7/14/1876	9. AGE last birthday 74 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Isaac Lowe			14. MOTHER'S MAIDEN NAME Elizabeth Travers		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. none		
17. INFORMANT AND ADDRESS Mr. Mace Willey, Cambridge, Md. RFD #2			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) _____ 442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (b) _____ 131a stating the underlying cause last (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify) SUICIDE HOMICIDE			PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/>		
			HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from APRIL 1949, to JAN 1951, that I last saw the deceased alive on 12 JAN 1951, and that death occurred at 4 A.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED M. C. Hensley Jr. MD Cambridge, Md. 13 JAN 51.					
23. BURIAL, CREMATION REMOVAL (Specify) Burial			DATE TIME OF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. 1/14/1951			REG. 24. FUNERAL DIRECTOR ADDRESS		
John Mace Jr. M.D.			LeCompte Funeral Service,		
Jan. 14. '51			Cambridge, Maryland		



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0464

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cambridge LENGTH OF STAY (In this place) 48 yrs			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge STREET ADDRESS Rm # 50 (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS REED 50			4. DATE OF DEATH JAN 3 1951		
3. NAME OF DECEASED (Type or Print)	(First) EDWARD	(Middle) R.	(Last) WILLIAMS	(Month)	(Day)
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12/2/1882	9. AGE last birthday 68 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman			10b. KIND OF BUSINESS OR Industry Fishing Indust.	11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Reed Williams			12. CITIZEN OF WHAT COUNTRY U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Herman J. Paul, Cambridge, Maryland	

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause
 Antecedent cause(s)
 93d Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(a) Chronic Myocarditis
 (b) Arterio Sclerosis - generalized
 (c)

7 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY	m.				

22. I hereby certify that I attended the deceased from Dec 31, 1950, to Jan 3, 1951, that I last saw the deceased alive on Jan 2, 1951, and that death occurred at 6:40 P.M., from the causes and on the date stated above.
 SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Hugh Brown *John Mace, Jr., M.D.* *Jan 4 1951*

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1/5/1951	NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park, Cambridge, Maryland	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 5. 1951	REGISTRAR'S SIGNATURE <i>John Mace, Jr., M.D.</i>	24. FUNERAL DIRECTOR LeCompte Funeral Service,	ADDRESS Cambridge, Maryland

JAN 8 1951

RECEIVED
D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

0465

1. PLACE OF DEATH- CITY OR TOWN Dorchester		2. USUAL RESIDENCE (HOME) OF DECEASED- CITY OR TOWN Maryland				
CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge		CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge				
LENGTH OF STAY (In this place) Life		STREET ADDRESS (If rural, give location) 225 High Street				
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hospital		4. DATE OF DEATH 1 30 1951				
3. NAME OF DECEASED (First) Hattie	(Middle) May	5. SEX Femail	6. COLOR OR RACE Colored			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-4-1880	9. AGE last birthday 70 yrs.	10. If under 1 year Months Days Hours Mins			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid	10b. KIND OF BUSINESS OR INDUSTRY Furniture Store	11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Jackson	14. MOTHER'S MAIDEN NAME Tamer Farrare	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 220-26-1322	17. INFORMANT Sarah F. Wallace, Cambridge, Maryland	18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH				
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
Immediate cause 8125	(a) Laceration and Contusion of Brain	8 hours				
Antecedent cause(s) 170c Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last	(b) Fracture of Skull	8 hours				
(c)						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive arteriosclerotic cardio vascular renal disease.						
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION INJURY street	21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) INJURY 1 30 1951 12:20 p.m.	PLACE (Home, farm, factory, street, of office bldg., etc.) While at work	(CITY OR TOWN) Cambridge	(COUNTY) Dorchester	(STATE) Maryland
				HOW DID INJURY OCCUR? Deceased was pedestrian struck by car.		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .						
SIGNATURE Eldridge H. Wolff		(Degree or title) Assistant Deputy Medical Examiner		DATE SIGNED 2-1-51		
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2-4-51	NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery	LOCATION (City, town, or county) (State) Cambridge, Maryland			
DATE REC'D BY LOCAL REG. 2-2-51	REGISTRAR'S SIGNATURE John Maece Jr. M.D.	24. FUNERAL DIRECTOR ADDRESS Herbert M. StClair, Jr., Cambridge, Md.				

